



Portion of jejunum resected showing polyps: A, irreducible invagination; B, invagination; C, double invagination below this point.

tion intravenously and subcutaneously. A rather severe stomatitis developed several days after operation, but cleared up readily with mouth-wash and application of Berwick dye. Several mild spells of diarrhea have been controlled by selected diet and small doses of tincture of opium by mouth. Patient left the hospital after three weeks. His appetite since leaving has been good, the bowels regular. He feels well and has gained twenty-two pounds. Cases in which long resection of small bowel has been done tolerate best a diet poor in fats, but rich in carbohydrates with moderate amount of proteins. Milk is not well tolerated, often passing rapidly through the intestines after ingestion.

This patient was seen four months after operation, was in excellent health, bowels regular, and his weight fifteen pounds above usual.

Pathological Report.—Multiple polypi. No evidence of malignancy. W. T. Cummins, M. D.

Sigmoidoscopic examination before discharge from hospital showed no evidence of involvement of lower sigmoid or rectum. X-rays of colon (barium enema) showed no filling defects.

COMMENT

After a review of the literature the infrequency of multiple polyps in the small intestines is appreciated. Most cases occur in the rectum and colon and occasionally in the stomach.

Ewing¹ wrote, "The ileum and jejunum are rarely affected," and mentioned Hauser, Kaufman, Lubarsch, Miemack, and Petrow as having reported cases.

E. L. King² in reviewing 119 cases of benign tumors of the small and large intestines reported no cases of papilloma in small intestine. Warwick,³ reports one case in which four polyps were found in the small intestines, together with two in the large intestine.

Z. Cope⁴ (*British Journal of Surgery*, 1922) reported a case of multiple polyps of the small intestine in which intussusception had occurred three times. He was misled at the first operation, believing the papilloma to be impacted bowel content, so after reducing the intussusception the wound was closed. At two succeeding operations the true nature of the tumors was discovered and the papilloma resected.

Petrow⁵ reported an operation for resection of papilloma of ileocecal valve, ileum, and jejunum which had caused intussusception.

W. L. Peple⁶ reported a case of polypoid tumor the size of a walnut, with a moderate-sized pedicle that had caused intussusception of the ileum.

Brenner and Denke⁷ reported a case of polyps of the small intestines that had caused intussusception. In their case, resection of 250 centimeters

of intestine was done. Patient recovered with "no digestive disturbances."

SUMMARY

1. The case herewith presented is of multiple polyps of jejunum causing intussusception in which over five feet of jejunum was successfully resected.

2. Intussusception of the small bowel is exceedingly rare.

3. Multiple polyps are usually found in the large intestines. The small intestine is rarely affected.

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MESENTERIC CHYLOUS CYSTS*

REPORT OF CASE

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THE subject of true chyle cysts of the mesentery is one concerning which there was, until the last eight or ten years, comparatively little on record in medical literature. Credit for the first formal article giving a more or less complete description of this condition is generally given to Rokitsky, who wrote at some length concerning it in 1842. Miles F. Porter¹ reported twenty cases in March, 1906, including one of his own. In 1912 Emmanuel Friend² summarized the world's literature up to that time, giving a report of fifty-two authentic cases. A year later A. L. Benedict³ made some additions and corrections to Friend's list, and reported a total of ninety-six cases, with the statement that perhaps two hundred cases might be found by extensive search. Later writers have added individual case reports.

An idea of the rarity of this condition in general hospital work may be gained from the fact that a search of the files of the Los Angeles General Hospital by one of the record clerks failed to reveal a single instance of its occurrence prior to the one herein reported. The records were examined as far back as 1912, and the only condition recorded as a mesenteric cyst was a myxomatous sarcoma of the mesentery operated upon by Dr. O. O. Witherbee in 1921.

Etiologically, nothing is positively known concerning the actual cause of these true chyle cysts of the mesentery. It has been thought that such

* Read before the staff of the Los Angeles General Hospital, October, 1928.

cysts resulted from a plugging of one or more of the minor lymphatic vessels, which anastomose after leaving the intestine, and that this plugging causes a gradual dilatation, resulting in cyst formation. As to age and sex, the occurrence in Benedict's series was in all ages, and about equal as to sex.

There are no pathognomonic symptoms or signs by means of which this condition can be positively diagnosed. There is most often a syndrome of vague abdominal pain, associated with the later development of a tumor mass which is usually quite freely movable, most often in the ileocecal region, quite soft and not tender.

The treatment of mesenteric chylous cysts may be summarized by the words of Porter in the article mentioned above:

"The treatment of mesenteric chylous cysts consists in their removal by that technique which seems best adapted to the case in hand after it has been studied through the open abdomen."

Mikulicz divided their treatment into: (1) aspiration; (2) marsupialization; and (3) extirpation.

REPORT OF CASE

Dolly W., girl, age five years, entered the service of Dr. J. L. Kirkpatrick at the Los Angeles General Hospital on March 2, 1927, complaining of pain in the abdomen. Two days previously the child had become ill with this pain in the abdomen. Temperature was 102.6 at that time. She did not vomit. Had had several similar attacks during the past two years, with the exception that fever did not accompany them. Had not been constipated. Past history was otherwise unimportant. Family history was irrelevant.

Physical Examination.—Patient was a girl about five years of age, lying on her back with the thighs flexed, apparently quite toxic, and in considerable pain, which pain was referred to the abdomen. General examination was negative except for the abdomen. The abdomen was moderately distended throughout, with considerable rigidity in all quadrants. Tenderness was present throughout, although perhaps more marked over the lower quadrants. There was the suggestion of dullness in both flanks. No mass was palpable. Temperature, 102; pulse, 132; respirations, 24.

Laboratory Findings.—White blood count: 28,000, with 85 per cent polymorphonuclear neutrophils. Urine: Trace of albumin, with many pus cells. No sugar or blood.

Diagnosis.—General peritonitis, probably secondary to ruptured appendix. An immediate laparotomy was performed.

Operative Findings.—Considerable thin seropurulent fluid was free in the peritoneal cavity. Some fibrinous exudate was present on the coils of small bowel. There was a large cyst of the mesentery occupying most of the lower abdomen. It was multilocular, about the size of two grapefruit, and was located about twelve inches from the ileocecal valve. It was so situated in the mesentery as to lie beneath a coil of gut about six inches in length, and apparently the blood supply of that portion of the bowel passed through the cyst. The two locules of which the cyst was composed communicated with each other under the coil of bowel described.

It was not possible to extirpate the cyst entirely without resecting that portion of the ileum involved. With the child's condition poor, it was decided to adopt more conservative measures. Consequently the cyst was aspirated of its contents—about six or seven hundred cubic centimeters of a milky fluid—the redun-

dant walls excised and their free borders closed with No. 1 plain catgut.

The abdomen was closed in the routine manner, and two rubber tissue drains were left in the pelvis.

The patient experienced a somewhat complicated postoperative course from extra-operative conditions, such as a streptoderma, a chalazion and a course of measles, but left the hospital with the abdomen completely closed and no signs of recurrence at that time.

The pathological report of examination of the portions of the cyst wall removed and of the fluid, as made by Dr. George Maner, confirmed the diagnosis of mesenteric chylous cyst.

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University of California Institute of Tropical Medicine to Open Next Year.—Tentative plans for the University of California Institute of Tropical Medicine, recently announced at the Hooper Foundation, research center of the medical school, provide for opening lectures in the summer of 1930, according to Dr. Alfred C. Reed, professor of tropical medicine.

The purpose of the new organization is threefold, Doctor Reed explains. It will provide the only western center for the treatment and study of tropical diseases, and for research in general problems of health and food preservation in the tropics or locally as a result of conditions having their origin in the tropics.

Research, public education, and treatment of individuals suffering from tropical diseases are given as the three phases of work to be carried on.

Under research, are included the practical problems of health and disease in tropical countries; the problems arising from shipping between the United States and tropical countries, both as regards cargo, and the personnel of the ships, passengers, and crew; and the problems presented by epidemics of tropical diseases such as meningitis, cholera, yellow fever, etc.

Under public education Doctor Reed lists four lines of endeavor. First, regular courses in tropical medicine for graduate physicians from every part of the world. Second, courses in tropical public health service for nurses going to tropical countries or on ships touching at tropical ports. Third, courses on tropical medicine for students in the University Medical School, as desired. Fourth, public instruction in tropical hygiene and public health through popular lectures and a course for prospective travelers, merchants, soldiers, and others intending to visit tropical countries.

Under treatment of individuals is included all such treatment as cannot well be taken care of elsewhere. It is thought that the university center will care for people in all parts of the West, as the next closest center for the treatment of tropical diseases is in Galveston. Another is located at New Orleans, but the rest are on the Atlantic seaboard. None of them, Doctor Reed says, are as wide in scope as that planned for the University of California.

Concerning the shipping problems to be studied, Doctor Reed explains that San Francisco, Los Angeles and other Pacific Coast ports are unloading places for innumerable cargoes of tropical goods, from copra, oil, forest products, and foodstuffs on down. This commerce, he says, not only offers a means of entry for tropical diseases and parasites of many kinds, but is itself often hampered by the action of parasites in cargoes en route. This is particularly true in the case of cargoes of foodstuffs, recent reports having been received of the spoilage of large cargoes of cocoa-beans by an insect parasite.—*U. C. Clip Sheet.*